ARIZONA HEALTH ACADEMY 2004
Maricopa Integrated Health System – Maricopa Medical Center
APPLICATION 2004 June 7 - July 23, 2004

(Deadline April 2, 2004 High school transcripts and two recommendation forms, two single sided copies of application packet must also be submitted)

PERSONAL INFORMATION: (please type or print neatly)

Name: *Last:* *First:* *M.I.*:

Social Security Number: – – Phone Number: ( ) –

PO Box or Street Address:

City: State: Zip Code: County:

Gender: ☐ Female ☐ Male Email: Birth date:

Citizenship: If not a US citizen, are you a permanent resident? ☐ Yes ☐ No

How do you describe yourself? (Please check only one)

- ☐ Asian/Pacific Islander: (Specify)
- ☐ Black/African–American
- ☐ Bi-Cultural/Other: (Specify)
- ☐ Mexican–American/Chicano
- ☐ Native American (Specify nation):
- ☐ Other Hispanic (Specify):
- ☐ Puerto Rican (circle) Mainland or Commonwealth
- ☐ White/Caucasian

How many brothers and sisters do you have? Ages:

Have any of your brothers/sisters ever attended/completed college? ☐ Yes ☐ No

EDUCATIONAL BACKGROUND:

High school presently attending (please spell out): City:
Present year in high school: ☐ 11th ☐ 12th

Science and Math education: List the titles and grades received for science and math courses taken in high school. (**Please note** that your high school transcript must be submitted along with your application.)

Science Courses	**Letter Grade**	**Math Courses**	**Letter Grade**
1.		1.	
2.		2.	
3.		3.	
4.		4.	

Do you plan to attend college? ☐ Yes ☐ No
Check all that apply: ☐ Community College ☐ 4 year Institution ☐ Other:(specify)
Have you attended any other summer programs? ☐ Yes ☐ No
If yes, when and where?

* Provision of this information is required. Applicants must be economically disadvantaged, "persons from disadvantaged backgrounds," ***or*** members of an ethnic minority group currently underrepresented in the health professions.

What are your career choices at the present time? Please number your top three choices, #1 being your first choice and #3, your third choice. If you mark any that say "Other" please specify what other career you would like to explore.

- ☐ Medical Doctor
- ☐ Health Science-related Ph.D.
- ☐ Pharmacist
- ☐ Nursing
- ☐ Public Health
- ☐ Physical Therapy
- ☐ Dental Hygiene
- ☐ Speech Pathology
- ☐ Other health-related career (not listed)
- ☐ Other science career (not health-related)
- ☐ Other (not science or health-related)

ACTIVITIES:

(A) List extracurricular and sports activities in which you have participated while attending high school.

(B) List any honors you have received while attending high school.

List jobs (paid or volunteer) held during high school, noting dates and approximate hours per week (babysitting and yardwork may be included)

Employer	Your Title/Position	Dates/Hours/Week

ESSAY QUESTIONS:

We wish to understand why you are seeking a health career in health professions and how our summer program could benefit you. You may type your responses on a separate sheet and attach. Please limit to maximum of 2 pages.

A. Which health profession do you want to pursue the most and why?

B. Name one major health problem in your community that you are aware of and how, as a health professional, you would address it?

C. What person or event has influenced your life thus far? Please explain.

D. What do you expect to gain by attending this summer program?

E. Describe any other special circumstance that you would like the selection committee to consider.

FAMILY BACKGROUND:

(To Be Completed by Parent or Guardian. Entire background information must be completed. Incomplete applications will be disqualified).

Parents' marital status: ☐ Married ☐ Divorced/Single Parent ☐ Legally Separated ☐ Widowed

If divorced, single, or legally separated, mark (✓) who has legal custody.

☐ Father	☐ Mother	☐ Guardian
Name:	Name:	Name:
Occupation:	Occupation:	Occupation:
Home Ph#: ( ) -	Home Ph#: ( ) -	Home Ph# : ( ) -
Employment Ph# ( ) -	Employment Ph# : ( ) -	Employment Ph#: ( ) -
Educational Background (check one):	Educational Background (check one):	Educational Background (check one):
☐ K-8 ☐ 9-12 ☐ College	☐ K-8 ☐ 9-12 ☐ College	☐ K-8 ☐ 9-12 ☐ College
Highest degree earned:	Highest degree earned:	Highest degree earned:

Has anyone in the student's family ever worked in a health care field? ☐ Yes ☐ No

If yes: Relationship to Student Health Care Field

How likely is it that your child, who is applying to this program, will attend college?

☐ Very likely ☐ Somewhat likely ☐ Not very likely

What would prevent your child from pursuing educational goals after high school?

How many people currently reside in your family household as reported to the IRS when filing your income taxes?

# of Adults # of Children

Most recent annual household income from all sources (please include AFDC, Child Support, Alimony, Pensions, etc.) as reported to the IRS on your Income Tax Form(s).

☐ Under $10,700
☐ $10,700 – $13,899
☐ $13,900 – $16,499
☐ $16,500 – $21,199
☐ $21,200 – $24,999
☐ $25,000 – $28,100
☐ More than $28,100 (please specify)

CONSENT / CONSENTO:

PARENT OR GUARDIAN MUST INITIAL EACH BOX TO INDICATE THAT CONSENT HAS BEEN GIVEN.

1. MEDIA RELEASE:

I hereby grant this program permission to record my child/ward's likeness and/or voice for use by television, films, radio, or printed media to further the aims of this program in related campaigns and magazine articles, booklets, posters and in other ways they may see fit.

CONSENTIMIENTO DE PUBLICIDAD DE PRENSA:

Doy mi consentimiento al programa y la oficina de Arizona Health Academy, Centro Medico Maricopa (Maricopa Medical Center, Maricopa Integrated Health System), incluyendo otros programas asociados con nuestro programa, para grabar la imagen o la voz, o ambas, de mi hijo(a) o estudiante bajo mi custodia para usar en la television, cinta de pelicula, radio, o en la prensa para campanas o articulos en revistas, folletos, cartelones y en otras maneras.

PLEASE INITIAL BOX TO INDICATE CONSENT ☐

2.CONSENT TO ACCESS ACADEMIC RECORDS:

I authorize and permit the staff of this program and grant partners to view and make copies of academic records and/or transcripts for purposes related to operating and studying the programs and activities.

PERMISO PARA ADQUIRIR DOCUMENTOS ACADEMICOS:

Yo autorizo y doy mi consentimiento al personal de la Arizona Health Academy de Centro Medico Maricopa (Maricopa Medical Center, Maricopa Integrated Health System), incluso los miembros del personal y otros programas asociados con nuestro programa, para que revise y haga copias de documentos academicos y certificados de estudios para la evaluacion de metodos, actividades y programas patrocinados por la oficina.

PLEASE INITIAL BOX TO INDICATE CONSENT ☐

3. Guidelines

- Arizona Health Academy requires a minimum of 200 clinical hours and two weekends of activities. In addition, students will be enrolled in college level courses and participate in field trips. An outside job, summer school, or summer camp is strongly discouraged and is only rarely permitted.
- We reserve the right to remove students from the summer program at any time for misconduct or noncompliance with policies and procedures.
- Arizona Health Academy is a "closed-campus" program i.e.: students may not leave campus for lunch or other activities without permission of parent(s) or legal guardian during program hours.

PLEASE INITIAL BOX TO INDICATE CONSENT ☐

I CERTIFY THAT I FULLY UNDERSTAND THE ABOVE GUIDELINES AND THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE AND CORRECT.

Signature of Applicant: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

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